EXTENSION OF HEALTH SERVICE COVERAGE BASED ON THE STRATEGIES OF PRIMARY CARE AND COMMUNITY PARTICIPATION

Summary of the Situation in the Region of the Americas

PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the WORLD HEALTH ORGANIZATION
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INTRODUCTION

The IV Special Meeting of Ministers of Health of the Americas was held at the Headquarters of the Pan American Health Organization in Washington, D.C., on 26 and 27 September 1977. Delegations of 28 Member Governments of PAHO presented reports, either orally or in writing, on the status in their countries of health service coverage and the strategies for its extension and improvement. Those reports reflected the findings of studies made by the Governments themselves immediately prior to the Meeting in the light of the document PAHO had made available to them entitled "Extension of Health Service Coverage using Primary Care and Community Participation Strategies" (REMSA4/4, Rev. 1).¹

This publication summarizes the reports presented at the IV Meeting of Ministers. It also provides an overview of the situation in the Americas, and covers the concepts of coverage, strategies for its extension or strengthening, and methods for the administration of services, as well as the most significant points of agreement or difference as regards the ways in which those concepts are being translated into practice in the countries. It sets forth the common factors which, according to the Governments, determine the situations described and summarizes the activities they plan to undertake in order to overcome the constraints and to adjust or strengthen the coverage process. Finally, as strategies at the hemispheric level, it describes the areas towards which, in the opinion of most of the Governments, technical cooperation and international financing should be directed under multilateral or bilateral agreements if the overall objective of health service coverage in the Region is to be achieved in the short term.

In the country reports an effort has been made to summarize in an orderly manner what is said in each concerning: (1) coverage, its characteristics and determining factors; (2) the strategies of primary care and community participation and the methods of applying them; (3) the immediate activities proposed for strengthening or accelerating the coverage extension process; and, where identified in the report, (4) the fields in which external cooperation is considered to be most effective.

¹Document REMSA4/4, Rev. 1, as well as the Final Report of the IV Special Meeting of the Ministers of Health of the Americas, the list of participants at that Meeting, and Resolution XXIV approved by the XXV Meeting of the PAHO Directing Council, are reproduced in PAHO Official Document 155 (1978).
I. Overview of the Situation in the Region of the Americas
I. OVERVIEW OF THE SITUATION IN THE REGION OF THE AMERICAS

The reports made by the Governments at the IV Special Meeting of Ministers of Health of the Americas contained the following proposals and conclusions:

They unanimously reaffirmed that the right to health is a prerogative of human beings that entitles them to claim an equitable distribution of opportunities and services that can help them attain the highest possible level of physical, mental, and social well-being.

It is the responsibility of the State to guarantee the full exercise of that right. Eight of the reports stated that responsibility was shared by all through the individual fulfillment of obligations both to themselves and to others.

All the reports repeatedly affirmed that the population must enjoy the highest possible levels of health that can be attained if their countries are to achieve appropriate economic and social development.

In that regard, the health field is so closely and intimately related to the other fields of development that it is impossible to individualize it. That is the reason why an understanding of health problems and the viability of their solutions call for a multisectoral approach and harmoniously coordinated intersectoral activities.

Health service coverage of the entire population in this decade is the common goal of the countries of the Americas. Efforts to achieve it are backed by specific policies designed to accelerate the process, improve the quality of the coverage achieved or incorporate new service areas that are acquiring high priority. These policies are embodied in the national health plans, most of which are integrated in theory or in practice into the overall development plans of the countries.

Coverage

The concept of and criteria for health service coverage set forth in Document REMSA4/4, Rev.1 was accepted as valid and it was reaffirmed that it continues to be a regional objective, as stipulated in the Ten-Year Health Plan for the Americas.2

It was acknowledged that health services are provided through two systems: one, the institutional system, and the other, the traditional community system.

The first comprises a group of public (state, parastate, or state-aided) agencies and private institutions directly or indirectly concerned with the provision of health services in one form or another. Indeed, the reports presented dealt with the service coverage and the strategies of the public institutions of the formal system and, in particular, of the ministries of health and of the institutions

under their direct authority or for whose coordination and control they are responsible.

Both profit and non-profit private health institutions participate in varying degrees in the coverage process. Over them the State exercises some measure of control and technical supervision as well as purely indicative authority.

In practice, the institutional system constitutes the health sector. In most of the countries this sector is not clearly delimited and is characterized by a large number of heterogeneous institutions whose structure and operations are both variable and complex.

Although the traditional community system exists in most of the countries, neither its structural characteristics nor its quality or actual coverage is well known; in some countries it is no longer possible to identify it, since it has been incorporated into the institutional system, and in three countries it is not regarded as important and its coverage is believed to be relatively circumscribed.

Even in the absence of satisfactory indicators of the real scope of coverage, most of the reports stated that, despite the considerable efforts made in the last ten years, the health services of the institutional system are not reaching large groups of the rural population and, in addition, are insufficient to meet the basic needs of the increasing number of persons who are settling in the marginal areas of the cities. In these countries efforts are at present aimed at accelerating the coverage process, special attention being assigned to the inhabitants of localities with fewer than 2,000-2,500 inhabitants or, in some cases, to the scattered population and to that of small communities with fewer than 500 inhabitants. In some countries the Governments are concerned not only about the shortcomings in rural areas but also about the increasing number of rural migrants to the major cities. In others, extension efforts are giving first preference to regional "poles" or centers of integrated development.

Certain countries rightly believe that they have achieved total coverage, at least in terms of access to services. This situation is attributable to the system and the policy of the government of the country concerned, its organization and its economic and social conditions or to the fact that universal coverage is favored by the relatively small size of the population, favorable geographical conditions, and good communication and transportation facilities. In those countries, the efforts of the system are directed towards improving the quality of the present services, their comprehensiveness, the opening up of new service fields and, in general, greater service efficiency and effectiveness.

All the reports acknowledged that the strategies of primary care and community participation are essential and decisive for accelerating the extension process and strengthening health service coverage.

**Primary care**

There was general agreement on the principles underlying the concept of primary health care as set forth in document REMSA4/4, Rev. 1 but the ways

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in which they are translated into practice in the different countries vary as regards:

- **Type or content of care:** (a) In most of the countries, services with a certain degree of comprehensiveness; (b) predominantly curative medical services in other countries.
- **Administrative or financial approach:** (a) Medical care extended throughout the country as a strategy for accelerating the coverage extension process; (b) provided in special programs; and (c) rudimentary and low cost (transitional arrangement made necessary by lack of resources).
- **Target:** (a) The rural population in general; (b) with greater emphasis on the scattered rural population or the population living in very small communities; (c) the population living in rural and urban marginal areas.
- **Situation in the system:** (a) First level of care, portal of entry or first contact with the institutional system; (b) at all care levels.
- **Type of personnel that provide it:** (a) Trained auxiliary personnel, in most countries; (b) multidisciplinary teams of the institutional system; or (c) physicians alone.

It was acknowledged that the concept and the content of primary health care are dynamic and will continue to evolve in each country and to be adapted to the changing needs of the community and the resources available.

It was pointed out that an important component of primary care is the education and training of individuals and the community for the purpose of creating a sense of responsibility for good health practices, developing a reasonable degree of personal and family self-reliance in preventing, or providing initial treatment of, accidents and simple complaints, and encouraging the prudent use of the health services made available to the community.

It was unanimously recognized that the strategy of primary care, regardless of the method selected for providing it, must be supported by active community participation.

**Community participation**

The concept of and criteria for community participation set forth in document REMSA4/4, Rev. 1 are consistent with those contained in all the reports that dealt with this strategy.

Generally speaking, it is to be noted that, in all the countries, community participation is linked, on the one hand, to the traditions and customs of the people and, on the other, to the mutually satisfactory fulfillment of reciprocal commitments between the community and the State, especially at the local level.

It was affirmed that the organization and capacitating participation of the community were essential requirements for ensuring that participation was active, conscious, responsible, deliberate and sustained. A well-defined policy of community participation that regards it as a democratic attitude or as a strategy for development enables participation to acquire those attributes.

In most of the countries, community participation primarily takes the form of the creation and guided operation of committees or boards or occasional contributions by the community—which may be moral, financial, in kind or in labor—for seasonal works or for dealing with emergencies.

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4Ibid.
Intersectoral coordination was affirmed to be necessary for ensuring the consistency and mutual support of the component activities of programs aimed at satisfying the basic needs of the community in any or all development fields.

In some countries, community organization has multisectoral objectives and is the responsibility of a state agency located at a high decision-making level. Community participation in health activities therefore depends on the coordination of the ministries of health with those agencies and on the priority assigned to the health sector in overall development programs.

Constraints

The constraints on the coverage extension processes and the strategies used for achieving it were emphasized. In addition to the factors mentioned in the reports there are undoubtedly others which, although not reported, are also important. However, those included are considered to be significant and reflect the present concern of the Governments of the Americas. They are detailed below together with their primary causes.

In all the countries there are constraints stemming from the way in which the health institutions, especially those of the public subsector, are organized and from the administrative processes. Those most frequently mentioned were as follows: in 23 countries there is a lack of coordination, or ineffective mechanisms for achieving it, both within and between research, teaching and service institutions in the field of the health sciences; 15 mentioned the large number of institutions involved, especially in providing health services; and six reported that administrative centralization is hindering the process and that planning, programming, supervision, evaluation, or logistics are inadequate.

In three-quarters of the countries, the constraints are attributable to the lack and unsatisfactory distribution or use of the health resources available: 18 countries cited, in the first place, shortages of financial resources; lack of human resources was mentioned as the most important constraint by 16 countries; material resources, especially their low productivity, by 13; and, lastly, inadequate and expensive technology, primarily because of the problems of dependence on foreign countries it creates, was noted by eight countries as an obstacle to the extension of coverage.

As constraints or problems, more than half the countries mentioned the high rate of population increase; ten stated that the persistence of small scattered communities was an obstacle; and seven mentioned the increase in rural migration to the cities as a serious problem.

The limitations caused by low rates of literacy and the existence of large population groups that speak not the official language but only an Indian language were mentioned by six countries; four mentioned resistance of the population to change; and three, that health leaders, especially professional health workers, are opposed to the reassignment of functions entailed by the application of strategies for the extension of services to marginal areas.

Finally, in ten countries the extension of service coverage to rural marginal areas and to the scattered population has been impeded by unfavorable ecological conditions: rugged topography, hostile environment, and difficult means of communication and transportation.
Although the national health authorities recognize these negative factors—many of which also affect the development of other sectors—they have adopted or are defining national policies that favor balanced economic and social development. This policy decision in all the countries of the Americas has made it possible to revise the administrative procedures for the production and delivery of health services, streamline the distribution and use of health resources, and strengthen the application of strategies that have proved useful or design new strategies that are politically and financially viable and socially just.

**Strategies**

All the reports described the principal strategies or strategic guidelines that are being used or would be used shortly as components or in support of the extension or improvement of health service coverage.

To present an orderly summary of these strategies the most important are grouped below according to: (a) administrative systems and processes; (b) health resources; (c) multisectoral approach to health problems; and (d) research and evaluation.

<table>
<thead>
<tr>
<th>Number of countries</th>
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<tr>
<td>a) Streamlining of functions and jurisdictions of the health institutions of the public sector and strengthening of coordinating mechanisms as a stage preparatory to the integration of services into a unified health system.</td>
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<td>• Strengthening of the programming of services in accordance with a better knowledge of the basic needs and health problems of the communities.</td>
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<td>• Support and encouragement of regional and local programming agencies.</td>
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<td>• Establishment or strengthening of regionalization, care-level and referral systems, including the design and application of practical and effective arrangements for coordinating the community and the first level of care of the service systems.</td>
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<tr>
<td>• Rationalization of the methods and procedures to establish or improve useful systems of information and communication.</td>
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<tr>
<td>• Streamlining and systematization of evaluation, supervision, and control activities at all operational levels, especially for connecting the first levels of care with the community, and in the operation of the referral system.</td>
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<tr>
<td>b) Adjustment of the production, distribution and utilization of health resources.</td>
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<td>• Updating of the contents and methods of teaching and training health personnel, in accordance with national strategies of primary care and community participation.</td>
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<td>• Adjustment of health education programs and capacitating participation of the community.</td>
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<td>• Establishment of new categories of health personnel at the local level of service delivery.(^5)</td>
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<tr>
<td>• Reassignment and/or appropriate transfer of functions of professional, technical, middle-level and auxiliary personnel.</td>
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<tr>
<td>• Study of present and future manpower requirements and establishment of</td>
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\(^5\)In order of frequency: community health aide, health promoter, paramedical personnel, dental aide, rural practitioner, etc.
interinstitutional coordination arrangements designed to ensure appropriate personnel absorption and distribution.

- Education and training of personnel, by multidisciplinary teams, as near as possible to the place to which they will be assigned.
- Conduct of local training programs with a view to developing a certain degree of personal, family, and community self-reliance and ensuring that prudent use is made of the health services available.
- Review of existing material resources, both facilities and equipment and supplies, in order to rationalize their quantity, distribution, adjustment, and operation.
- Recuperation of installed capacity, including increase in days and hours of service, especially at the primary care levels.
- Emphasis on improving the quality of services, especially when a reasonable total coverage has been achieved.
- Inclusion of new service areas in the extension of coverage.\(^6\)
- Expansion of the network of health services to enable them to cover unserved rural areas.
- Rationalization of the use and distribution of financial resources, including investment and cost studies.
- Preferential channeling of resources to the population of rural marginal areas.
- Increase in resources for financing preventive services and health promotion.
- Review of technologies in use in the eco-biological and administrative fields for the selection, adaptation, or development of appropriate technologies.

(c) Increase in efforts to connect health services more closely with those of other social and economic sectors and to obtain the collaboration of all for the development of those sectors.

- Effective coordination of health programs and activities or health-related programs with those carried out by institutions in the fields of education, housing, agriculture, transportation and industry and social security.
- Formulation, reactivation or updating of policies supporting the multisectoral approach to health problems.
- Coordination of teaching, research and service activities within each institution and with those carried out by specialized teaching and research institutions in related fields.

(d) Promotion and development of research or evaluation activities in fields relating to the general coverage extension process or in those relating to the traditional community system, its characteristics and technologies, especially those of folk medicine, or research for the creation or adaptation of appropriate technologies.

These strategies are only a small selection of the many that may be used and are already being used to a greater or lesser extent in the countries; they are strategies that have proved to be politically and financially feasible in some countries. The regional application of all the principal strategies on which the governments of the countries of America have agreed will soon lead to the achievement of the overall goal of health service coverage.

\(^{6}\) Such as geriatrics, occupational health, industrial medicine, community psychiatric care, cardio- and neuro-vascular clinics, diabetes, speech therapy, chiropody, and the like.
II. Summary of the Reports Presented by the Countries
1. In August 1977, the Secretariat of State for Public Health made its recommendations on policies and strategies for accelerating the extension of coverage of health services in all the politico-administrative jurisdictions of the country. These recommendations were formulated in the light of the experience gained in conducting comprehensive health programs in rural areas of the Northeast, the Northwest, the Center, and Comahue, as well as in the conurbations of Greater Buenos Aires, Greater Cordoba, and the city of Buenos Aires.

"Population covered" was defined as the population whose basic health needs, house by house and person by person, are satisfied by the health system on a programmed and continuing basis and at the most adequate health level.

The scope of coverage is not known, but it is recognized that under present conditions it has not been possible to satisfactorily meet the growing basic health needs of the scattered rural population or of the impoverished groups that are settling in the cities and their outskirts. However, most of the population is concentrated in urban areas.

At the same time, it is recognized that the experience gained with programs aimed at these groups in the interior of the country has been positive and has shown that they can be replicated and given a national dimension and that the application of the strategies of primary care and community participation can be strengthened, provided they are in all cases adapted to the conditions and sociocultural characteristics of the communities themselves.

Furthermore, the rapidity and effectiveness of the process of coverage extension demands that a multisectoral approach to health problems be adopted, well-defined health policies introduced, resources adjusted, and their management coordinated if increased productivity and equitable distribution are to be obtained.

2. Primary health care and community participation are considered to be the indicated strategies for achieving the extension of coverage of health services to the entire population of the country. Primary health care means the set of simple activities programmed to satisfy the basic health needs of a community; it constitutes the first level of the institutional system of health services and the first contact of the individual and of the population with the system.

In Argentina, primary health care workers are trained by multidisciplinary personnel in accordance with the local characteristics and are preferably drawn from the communities they are going to serve as health agents, nursing auxiliaries, social workers, general practitioners and the like. These primary health workers establish direct and continuing relations with the communities and promote their active participation through a gradual process of education and capacitation that ensures their cooperation in all stages of the programs.
3. The application of the above-mentioned strategies on a national scale has led to a thorough review of the institutional structures of the health sector, as well as of the methods of educating, training, and capacitating human resources at all levels. This review will produce new guidelines for identifying and evaluating the needs and resources of the community; adjusting the organization and functions of the health infrastructure; developing and making efficient use of the available resources; and creating new resources.

To ensure the achievement of these purposes, efforts are being made to streamline administrative processes, especially programming, promotion of intra-sectoral coordination, establishment of care levels, and regionalization of the health delivery system, and strengthening and improvement of the efficiency of the referral, supervision, evaluation, and information systems and especially to ensure that the activities of research, teaching, and service institutions are directed towards rural areas.

These principal purposes are included in a national health plan which is an integral part of the National Overall Development Plan. The approval and implementation of the National Health Plan is under study.
BARBADOS

(Summary of the Report Presented)

1. The Ministry of Health and National Insurance is the government agency responsible for the health of the people. Barbados is a small country without mountains or rivers and with very good road communications; there are thus no isolated communities. The entire population is accessible to health personnel and can easily get to an institution for medical care. Therefore, from the point of view of accessibility, the entire population is already covered.

2. Sociocultural and geographic conditions favor the active participation of the communities as well as the coordination of activities within the health sector and of those with related activities of other social and economic sectors.

3. The improvement of the quality of medical services for all and a reduction in the high cost of drugs are at present the major concerns of the Government. In October 1976 a committee was appointed to plan a National Health Service that will embrace and be responsible for all health activities.

4. To ensure that enough health personnel are available to provide the services, special attention will be given to the preparation and development of manpower at the auxiliary and paramedical levels. A program is now under way for the construction of polyclinics that will offer a wide range of specialized medical services supplementing those provided by the existing health centers. The delivery of primary health care will remain in hands of the general practitioner. One of the strategies being examined is that of assigning specially trained nurses to relieve doctors of certain time-consuming duties. A study on the administration of health services with a view to their reorganization to ensure optimum use of limited manpower resources has been completed.

5. To reduce the high cost of drugs, the Government plans to prepare a national formulary to secure standardization; to purchase drugs under their generic names and so supply them through its dispensaries; and to discontinue the use of brand names in prescriptions.
BOLIVIA

(Summary of the Report Presented)

1. In addition to that of the institutional system, some service coverage has been provided, because of the characteristics of the country, by the traditional system which consists of community workers who from time immemorial have carried out health activities on an empirical basis. The scope of the coverage of the traditional system has not yet been quantified, although it is believed to be considerable, and the quality of the care it provides is a matter of concern to the institutional system.

The institutional system is made up of the Ministry of Social Welfare and Public Health, the social security system, and the private sector, which account for 60, 30, and 10 per cent respectively of its coverage.

Because of the dispersion of the population, its limited accessibility, its cultural patterns, and its different socioeconomic levels, two clearly defined areas, the urban and rural, must be differentiated in analyzing this institutional coverage. The urban area, which comprises 40 per cent of the total population of the country and is made up of communities with more than 10,000 inhabitants, has most of the human, physical and financial resources, and consequently its population has greater possibilities of access to all care levels, including the most sophisticated levels. In the urban area the average number of consultations is three per person per year. Worthy of mention are the marginal sectors of certain cities, which consist for the most part of rural migrants not covered by the social security system. The coverage of these marginal sectors is very low and in sharp contrast to that of other groups in the same area.

The rural area, which comprises 60 per cent of the total population of the country and consists of communities with fewer than 10,000 inhabitants, is served exclusively by the Government through the services provided by the Ministry of Social Welfare and Public Health. In this area the average number of consultations per person per year is less than one. This situation is attributable to a number of limiting factors, foremost among which are the following: the dispersion of the rural population, 42 per cent of which lives in communities with fewer than 200 inhabitants in a geographical area of more than one million square kilometers, a fact that militates against the organization of basic health services; difficult geographical access to services, because of that dispersion and limited means of communication; varying levels of education; and traditional cultural patterns that hamper an understanding of health problems.

2. Accordingly, the aim of the National Economic and Social Development Plan, 1976-1980, is the full realization of the Bolivian man. This will be achieved through the geographical, economic, social, political, and cultural integration of the country, the transformation of an economy based on primary and extractive
activities into an industrial economy; self-sustained growth of wealth and high levels of income, and the promotion of its rational distribution in such a way as to make it possible to provide the population with all the services necessary for improving their living conditions.

The objectives and policies of the National Health Plan as well as the strategies included in it are fully consistent with those of the Economic and Social Development Plan, since it is established that health activities are basically and preferably aimed at dealing with and solving the health problems of the rural area through joint and coordinated activities by the institutions of the health and other sectors.

3. In this context and with a view to raising the level of health of the population the following policies have been defined: (a) to fit all health programs into the overall framework of integrated development, on the understanding that the health sector is one of its components; (b) to give priority to rural and urban marginal communities by extending and improving service coverage; (c) to give special attention to preventive and health promotion programs and services because of their greater impact on improving health; and (d) to provide sufficient health manpower appropriately trained to meet the real needs of the country.

The strategies used for that purpose are the following: to increase health activities through a radial system of service delivery to the communities, priority being given to rural and urban marginal areas; to use the manpower, both traditional and extra-sectoral, available in the community and to connect it with the institutional system following appropriate training and under continuing supervision; to increase health education activities through the formal education system and the activities of the health services themselves; to conduct research to obtain a better knowledge of health problems; and to develop new technologies tailored to conditions in the country.

For the expansion of coverage in the rural area, the plan comprises two stages: the first, which is being implemented, involves the strengthening and improvement of the infrastructure and the expansion of programs and activities that will make it possible to extend health activities; appropriate and efficient use of resources; improvement of productivity with increasing deliberate, organized, and conscious participation of the community in all phases of the development of health programs and activities.

The second stage, which will begin shortly, will cover the extension of health services to the entire rural area that is at present unserved, within the framework of integrated rural development. To that end, a comprehensive study will be made, basically covering the following: analysis of the present and future behavior of the population in accordance with existing conditions and expected changes in socioeconomic factors; definition of care levels and of the needs of those levels, which will make for proper distribution and determination of the type and scope of services, including their location in uncovered geographical areas, within the framework of a regionalization and referral system; determination of the construction, equipment, and installation of new health facilities for expanding coverage in areas that lack both infrastructure and services.
The first stage of this plan is already under way and involves an initial investment of 400 million Bolivian pesos. The preliminary results of this system of service coverage expansion within the framework of integrated rural development, in which the Ministries of Agriculture, Education, Housing and Sanitation are also participating, are very promising. However, the results of its future large-scale implementation will not be visible until the end of the five-year period, 1976-1980.
1. The Ministry of Health, the Departments of Health of the States, and the Ministry of Social Welfare and Assistance, which has recently been established (1974), are the principal agencies of the public sector providing health services in the country. The functions of the first mentioned are primarily aimed at solving problems affecting communities; those of the Departments of the States, at delivering medical and health services in their respective jurisdictions; and the functions of the new Ministry, at administering services to individuals within a social security system. Basic sanitation problems are primarily dealt with through the Ministry of the Interior. The coordination of the activities of these federal agencies is the responsibility of the Social Development Council (CDS), which is headed by the President of the Republic.

The actual scope of health service coverage in the country as a whole is unknown. As in most of the countries of the Hemisphere, the services are concentrated in the largest cities where the population is also concentrated. A high proportion of the population living in smaller towns and in rural areas lack services or only receive them sporadically. The scattered nature of the rural settlements, the topography, the hostility of the environment, and the vastness of the territory, accentuate the problems that affect the coverage process.

2. Primary health care, based on a multidisciplinary approach, and community participation, are the most important strategies in regional and district development programs in the rural areas. The Ministry of Health primarily devotes itself to satisfying basic health needs. Its activities are extended to communities with up to 400 inhabitants in an integrated program that includes activities for basic sanitation, the provision of safe water, the improvement of rural housing and the maintenance of useful levels of protection against diseases preventable by immunization. In addition, it undertakes activities for the control of vectors and reservoirs of infection, provides perinatal and maternity care, deals with the commonest local endemic diseases, and is responsible for the referral of persons when the solution of their problems requires services at a higher level of complexity.

Regional networks consisting of chains of service units of increasing complexity have been established. The communities themselves are involved in the operation of these services. Their participation, especially in basic sanitation work and the construction of water supply services, includes the administration and maintenance of the services. A national community capacitation program designed to rationalize their participation and thus to foster self-confidence and a reasonable degree of self-reliance is being planned. It is also planned to revise the program for the training of health manpower so as to adapt it
to the actual absorption capacity of the labor market and its possible expansion as a result of the coverage extension process. In 1977 a public health career service was instituted and is open to university-trained and middle-level professionals in the health and related sciences. After being appropriately trained these professional and technical workers will form multidisciplinary teams and be responsible for the orientation and operation of the coverage extension process.

3. Extension of health service coverage is included among the principal objectives of the national overall development plans. It is being undertaken as a gradual process that runs parallel to that of regional and district integrated development programs. These programs are determined on the basis of criteria imposed by the greatest need and demand. For the extension of coverage all the institutional resources of the public sector in the health field have been brought into play. Education, food production, and improvement of rural housing are fundamental development fields for strengthening health activities. Intra- and intersectoral coordination mechanisms at all decision-making levels will be strengthened. The review of technologies for the purpose of adopting the most appropriate, even in the field of administration, will be continued. Special attention will continue to be given to the education, capacitation, and training of human resources at all operational levels. These purposes, which have been summarily set forth, are supported by appropriate legislation that has been enacted in the last three years and is in force.

4. In coordination with the other components of the CDS and regional development agencies, the Ministry of Health is making heavy investments in infrastructure, primarily in the most impoverished regions of the country, in order to ensure that the purposes set forth in sections 2 and 3 above are achieved. Between 1975 and 1977, a total of 253 basic health units of various types were constructed and enlarged; of the 400 water supply systems planned for the five-year period 1975–1979, 281 have already been built or enlarged; and thousands of other improved sanitary facilities, both collective and domiciliary, have been built, especially in areas where schistosomiasis is highly prevalent.

In the period 1975–1979, the investments of the Ministry of Health amounted to Cr$4.8 billion (at 1977 prices): of this amount, Cr$4 billion was for health and Cr$800 million, for sanitation.

The 1978 targets of the Program for the Provision of Health and Sanitation Services in the Northeast, which is coordinated by the Ministry of Health, are the installation of 2,723 basic health units, 1,302 water supply systems, and 321,000 latrines. This will make it possible to extend coverage to 8.8 million persons in 856 municipalities at a cost of Cr$2.2 billion.
1. The responsibility for planning, financing, and delivering health services, for health sciences education, and for the regulation of the health professions lies, in general, with the provinces. The federal government plays a major role in health protection, through activities relating to environmental health, food and drug standards, and the non-medical use of drugs. Since 1948 the federal government has been making grants to the provinces to assist them with general and special health programs, training, research, and the like. These grants paved the way for the introduction throughout Canada of hospital and medical care insurance programs. The federal government pays the provinces half the cost of such programs if they meet specified criteria as regards public administration, comprehensiveness, and portability from one province to another.

In 1964, the Royal Commission on Health Services in Canada described the conceptual basis of health services coverage in its Health Charter for Canadians: "The achievement of the highest possible health standards for all the people must become a primary objective of national policy and a cohesive factor contributing to national unity, involving individual and community responsibilities and actions. This objective can best be achieved through a comprehensive, universal Health Services Program for the Canadian People ..."

A decade later "A New Perspective on the Health of Canadians" reflected the advances made in achieving the goals embodied in the Charter and noted that the improvement in the environment and an abatement in the level of risks imposed upon themselves by individuals, taken together, constitute the most promising ways by which further advances can be made.

It can be reasonably claimed that the Canadian health care system is providing generally good coverage; however, there are still problems to be resolved. To cite some: resources are skewed towards treatment and away from prevention and even the treatment services may lack coordination; resources tend to flow to major population and economic centers, leaving the poorer, rural areas relatively underserved; many small institutions are too small to be efficient; the cultural aspects of the community, particularly where there are large ethnic minority groups, are not considered when services are planned.

The distinction between the traditional community system and the institutional health system is not commonly made in Canada. Recently, however, there has been considerable discussion of the need to promote "personal responsibility for health." This term embraces the concept of reducing risks by improving one's lifestyle and the concept of avoiding unnecessary use of health care services for minor ailments which the individual or his family should be capable of managing without professional assistance. The traditional community system is being increasingly recognized and emphasized in the health services directed to indigenous groups: Indian and Inuit (less than 1 per cent of the total population).
2. The term "primary health care" has been used in Canada to describe types of care, types of personnel providing care, administrative/financial approaches to care, or organization of services. In general terms, it implies an effective organization that permits a variety of health workers to function as a team and to fulfill the following responsibilities among others: provision of primary contact for the public within the health system 24 hours a day and seven days a week; determination of the kind of services required by the individual at a given time; provision of health care to the individual and the family, including promotion and preventive measures, based on a continuing health personnel/service user relationship of understanding and mutual confidence.

The community health center is considered the nucleus from which individuals and families obtain initial and continuing health care of high quality.

Community participation in Canada is tied to its commitment to the democratic form of government and the traditional beliefs and practices of the Canadians that are reflected in their extensive voluntary involvement in the health sector.

3. The most significant discrepancies between the conceptual bases of health coverage, primary care, community participation, health system, and the current national processes were clearly identified and analyzed in the paper presented to the Ministers' Meeting. To overcome these discrepancies, strategies have been proposed or are currently in operation. The most important of these strategies may be summarized as follows:

**Health services coverage.** Greater emphasis on the environmental and lifestyle components of the health field; channelling of health manpower to underserved rural areas; teaching and service on geriatrics; more intersectoral approaches to health and health-related problems; increased constraints on hospital construction; health education of the population on appropriate use of services, including traditional community methods; and early identification of high-risk groups.

**Primary health care.** Programs to encourage team work; improvement in accessibility by reducing the remaining economic and cultural barriers; extension of hours of operation of services; and improvement of referral systems and coordination of health and health-related services.

**Community participation.** Establishment of community/regional health planning bodies and consolidation of citizen boards/councils; improved training programs for both community members and public health workers to enable them to participate at all levels, and exploration of new approaches to community participation (e.g. patient ombudsman).

**Health services system.** Increased emphasis on identifying specific needs and developing services to meet them; extension of regionalization of planning and services; establishment or extension of training programs in the fields of geriatrics, occupational health, chiropody, dental nursing, and speech therapy; and rationalization and overhauling of the administrative processes at all levels.

These strategies are only a small selection from many which might be or have
been employed to a greater or lesser degree in various provinces, have proven to be effective, and are politically and economically feasible. Taken together, they would, over time, lead to substantial improvements in health service coverage based on the strategies of primary health care and community participation.
CHILE

(Summary of the Report Presented)

1. Health is a human right embodied in Constitutional Act No. 3 of the Republic. It is considered part of the national wealth and the State is made responsible for guaranteeing to all without discrimination free and equal access to the services provided through the various public and private institutions of the health sector. The government agency charged with that responsibility is the Ministry of Public Health. The services it delivers must be comprehensive; prompt and efficient; and total in coverage. Health policies are part of the general policy of the country and are aimed at solving the most important or urgent problems.

The state of health of the country is considered to be intermediate between that characteristic of a developing country and that corresponding to a more developed country. It is a difficult situation to deal with since, on the one hand, there are basic health needs that require satisfaction through very broad coverage throughout the country and, on the other, demands characteristic of the pathology of industrialized countries that call for expensive and highly complex specialized services. The purpose of the present health policies is to balance the decisions involved in the specialization/coverage dilemma, taking into account the constraints imposed by the available resources and the slow economic development of the country. Although the trend of the health indices is towards improvement, they still reflect problems that are far from having been solved, such as refusal by patients of the services at the primary care level, unemployment at the intermediate level and, in general, lack of satisfaction both of users and of health workers. All of this in the context of an adverse ecological situation that produces large-scale health problems.

2. Given an ambitious conception of health and of the role medicine plays in it, a proud tradition in the matter of service and a frankly unsatisfactory situation, the Government plans to raise the health level of the entire population of the country through the implementation of policies in the following areas:

a) Services to individuals and environmental activities. Its general purpose is to extend the coverage of health services to the entire population in the form of high-quality, integrated health activities provided by a three-level care system: a primary level of maximum coverage and minimum technical complexity; a secondary level of medium coverage and medium complexity; and a tertiary level of minimum coverage and maximum technical complexity.

b) Organization and structuring of the Ministry of Health, both at the central administrative level and at the regional level, based on a scheme proposed by the National Administrative Rationalization Committee (CONARDA). This scheme calls for the establishment and strengthening of a system of regionalization
and the design of plans of proven efficiency in the fields of medical care, administrative structures, training and use of human resources, information, financing, and evaluation systems. Also included is the establishment of a National Compensation Fund, the functions of which are to collect both the direct contributions of the State and those coming from the social security system and to distribute them equitably in accordance with regional needs and national priorities.

c) Development of human and physical resources, which includes: studies of present and future manpower requirements and establishment of coordination mechanisms for their appropriate distribution; studies for the reassignment of the functions of health personnel; and the development of a career health service appropriate to a modern administration. As regards physical resources, efforts will be made to ensure better distribution of them in accordance with the needs of the system for the regionalization of services by care level and the recuperation of installed capacity, both by programs carried out by the ministerial system itself and by the use at real costs of extra-ministerial and private institutions.

d) Research and health education, aimed at operational research on the aspects proposed in the foregoing fields and the preparation of the contents of the health education program. The policies mentioned are being fully implemented in 1977.
COLOMBIA

(Summary of the Report Presented)

1. The National Health System of Colombia, which comprises all the public and private institutions of the health sector, has been in operation since 1975. The Ministry of Health, the directing and coordinating agency of the system, has established and is developing health policies. These policies are embodied in a National Health Plan, which is an integral part of the Economic, Social, and Regional Development Plan. The principal objectives of the National Health Plan are improvement of the quality of health services and extension of their coverage. The mechanisms for achieving those purposes include the regionalization of institutions and their ranking by care levels: health posts and centers, staffed by auxiliary personnel that provide primary services; local hospitals or equivalent units of a general type, staffed by professional personnel who provide secondary services of greater complexity; and tertiary or specialized services that are provided in university hospitals. The coverage extension policy emphasizes the provision of services to high-risk groups and to those living in urban and rural marginal areas. Despite the efforts made, the coverage of the health services is estimated at only 64 per cent of the total population.

2. Within the system of care levels, primary care consists in the provision of simple, comprehensive services for the protection, promotion and recovery of the health of individuals, families, and the community. These services are provided at the local level by trained auxiliaries under the continuing supervision of professional personnel. Primary care is considered the most important strategy for the extension of service coverage and therefore great attention is being assigned to the training of personnel at this level and at the higher supervisory levels as well as to the reassignment of functions to auxiliary personnel.

It is recognized that this strategy must be supplemented by the organization of the active participation of the community in community health and welfare matters. To that end, participation "models" and mechanisms have been designed and include such essential elements as the promotion and organization of participation; individual and collective capacitating participation; and the supervision and evaluation of the process. Both in the urban and in the rural marginal areas, programs based on development of primary care services and community participation, within the system of care levels and regionalization of institutions, have been initiated.

Specialized programs and direct campaigns have been integrated with multidisciplinary functions in the process of coverage extension. They include the malaria eradication service; the community psychiatry service; and the environmental protection program, which is coordinated with development institutions of the public sector, municipal institutions, and institutions of the private sec-
tor, coffee growers, and regional corporations. The starting point of the multi-sectoral approach to health problems is also primary health care and community participation and is embodied in the Food and Nutrition Plan, in the Integrated Rural Development Plan, and in the Program for the Rehabilitation of Urban Marginal Areas. The strategies and programs mentioned, as well as the human and technical elements involved in them, are being carefully studied and evaluated as part of a program of "Research on Service Delivery Modules," the findings of which will be used to confirm, modify, or readjust methods and procedures used in the coverage extension process based on the strategies mentioned.

3. At the national level, efforts will continue to be made to integrate and coordinate resources within the National Health System; strengthen the regionalization of services by interrelated care levels; strengthen primary health care; capacitate the community to participate in health matters; educate and train personnel, to which new functions will be assigned; utilize and guide the resources and efforts of private agencies in programs for the extension of coverage; and strengthen intra- and intersectoral coordination mechanisms both at the national and at the regional and local levels.

To that end, an integrated planning method is being developed whereby the diagnosis-decision-programming-execution-evaluation stages will be processed by the National Health System and health-related services and activities will be coordinated on an intrasectoral and intersectoral basis and with the communities.

To develop methods of communication for the proposed coordination, the first Community-School has already been established. Its objectives are as follows: (a) testing and adjustment of the new methods developed by the sector; (b) coordination of the various sectors with one another and of all of them with the communities; (c) development of a synergic process of external financing; (d) teaching; (e) research.
COSTA RICA

(Summary of the Report Presented)

1. The right to health of all the inhabitants of the country is recognized by the Constitution and guaranteed by the State, through the provision of services by the Ministry of Health, the coordinating and directing agency, the Costa Rican Social Security Fund, the Water Supply and Sewage Disposal Institute, and other public and private institutions of the health and related sector. During this decade, the legal bases of social development programs, especially in the health field, have been strengthened, as have been the mechanisms for coordinating or integrating the institutions that carry them out.

The essential purpose of the National Health Plan, formulated within the context of the National Development Plan, is to deliver to the entire population services that will satisfy their basic, individual and collective needs in an integrated and effective manner. To achieve this objective, which is tantamount to total health service coverage, new strategies have been employed: universal health insurance; the accelerated development, within the service system, of a level of primary health care based on community participation; and the strengthening of mechanisms for the coordination of the social security and public health systems with a view to integrating them into a unified national health service.

The extension of health service coverage is a process, backed by a firm policy decision, that is in an advanced stage of development. It may be said that the entire population of the country has access to institutional health services. The present concern is to ensure that coverage in the rural, periurban and intermediate areas is effective, comprehensive and continuous. Although the results obtained are very promising, there are still a number of obstacles and limitations to be overcome since they are affecting the speed with which the process is proceeding. Primarily they are the lack of unsatisfactory distribution of human, material, and financial resources; persistence of defects in the administrative process of the institutions of the sector; and resistance to delegation or transfer of functions traditionally performed by professional or technical personnel to auxiliary personnel.

2. Since 1971 a national rural health program has been in operation and is aimed at providing the more isolated rural communities with basic health services. These services include simple but effective health activities carried out by trained auxiliary personnel, lay midwives, rural health assistants, nursing auxiliaries, volunteer promoters, and community health aides. The last-mentioned are to take part in a similar program in urban marginal areas. The core of the two programs, the rural and the urban community, is primary health care and active community participation; they have received political and economic support and are the subject of an ongoing evaluation and consequently of
changes that are refining the programming and adapting it to better defined local needs.

The conscious cooperation and participation of the community in local social development programs has been stimulated and sustained by the law on Social Development and Family Allowances, which established a fund for financing social programs and services, pensions, food supplementation, care of the aged and the like, for low income families. The Fund also finances programs of research, teaching and services in the field of nutrition as well as intersectoral programs of training, land settlement and the like. The General Directorate of that Fund also coordinates the various programs of technological transfer to farmers.

In the field of health technology, areas of research have been identified for the purpose of establishing appropriate technologies that will facilitate both services to individuals and environmental activities in the coverage extension process.

3. So far, the above-mentioned strategies have proved to be those indicated for accelerating the process of the extension of health service coverage. Negative factors have been identified, essentially administrative factors, which affect the process, and systematic measures are being taken to neutralize and overcome them. Furthermore, the attitudes and activities that have had a favorable influence on the considerable advance made in recent years are being strengthened and reinforced.

4. Since the extension of health service coverage based on the strategies of primary care and community participation is a common goal of the countries of the Americas, Costa Rica again proposes the establishment of a Pan American Center with the following purposes: compilation and distribution of information on experiences and progress made in the countries towards achieving that goal; research on appropriate technologies; capacitation and training programs for key personnel; and organization and orientation of technical cooperation among the countries. This will ensure that more efficient use is made of the resources stemming from the cooperation and solidarity of the countries of the Hemisphere.
1. The Constitution of the Republic embodies the right of all citizens without distinction to receive health care and protection. The State guarantees that right by providing free medical and hospital care through a network of rural medical facilities, policlinics and hospitals, prophylactic centers, and specialized treatment institutions. The State is responsible for health education plans and programs, health extension work, general immunization programs, periodic medical examinations, and environmental protection and health activities.

All the population cooperates in these plans and programs, and in those for social and economic development, through its social organizations. The application of the concepts of integrated medicine, the provision of all health services free of charge, universal access to primary care units and, basically, the participation of the people, who are increasingly trained in health activities, have helped to raise the level of living and health of all the inhabitants of the country and are responsible for the progress made in the areas of education, employment, food, housing, recreation, and other social programs under way. The institutional health service system represents the National Health System, which is directed by the Ministry of Public Health. As a result of the achievement of total health service coverage and of the achievements of other social development sectors, it is not at present possible to identify the "traditional community system," since what is usable and useful in it has been adapted and incorporated into the national health system. The national health system includes and integrates in its operations all the elements of the health sciences and techniques that the State makes available in the fields of medical care and environmental health; social services for the aged and the disabled; manpower education and specialization; research and biomedical information; production and distribution of drugs and medical equipment; and the preparation and control of financial and investment plans.

2. In the national health system there are three levels of care, all of which have integrated health services. Health activities at those levels are closely interrelated and thus guarantee the delivery of services consistent with the complexity of the individual, collective, or environmental problem that has to be solved. Primary health care is provided through what is known as the "primary medical care level"; it consists of a set of primary activities for the promotion, protection, and restoration of the health of individuals, as well as activities for protecting and upgrading the environment. These activities are carried out by teams of professionals, technicians and health workers attached to established institutions (policlinics, rural hospitals, and medical posts), together with active and effective community participation. As part of the system of functional regional-
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The policlinics are responsible for primary health care activities and are the basic elements of the service coverage of the rural and urban population.

The present primary care model in the country—which is based on work in four basic specialties: internal medicine, pediatrics, obstetrics and gynecology, and stomatology—is a result of a process of development over a period of 19 years coupled with an increase in human and material resources intended for the health sector. This model, which will continue to evolve in accordance with the changing needs of the community, development possibilities and the qualifications of human resources, cannot be viewed at this time as suitable for all countries.

3. As a result of the changes brought about in recent years, both in the structure of the population and in the epidemiological situation, health needs and demands and consequently the contents and priorities of primary health care services have likewise changed. In the immediate future those services will focus on the following main activities: increase in maternal and child and school health programs; expansion of the occupational health program; improvement of the program of medical and social care for the aged; strengthening epidemiological surveillance in order to prevent the introduction of new diseases or the re-introduction of those already eradicated; reinforcement of communicable diseases control programs and rational increase in those designed to control cardiovascular, diabetes, and other metabolic and degenerative diseases; conduct of research programs and services in the field of water, soil, and air pollution.

4. Since total health services coverage and the application of the strategies of primary health care and community participation should be adopted as express health policies and assigned high priority, the organization, increase, and exchange of experiences and of collaboration between the countries of Latin America and the Caribbean that are at a similar socioeconomic level is recommended. This cooperation could range from exchange of information to collaboration in the education and training of manpower in areas in which each country has obtained successful results.
DOMINICAN REPUBLIC

(Summary of the Report Presented)

1. The extension of health service coverage to the entire population of the country continues to be the primary objective of the national health plans for whose implementation the Secretariat of State for Health and Social Welfare is responsible. A number of different institutions provide health services, particularly medical care services for the treatment of diseases; however, the supply and accessibility of the services, both in quantity and quality, is always less than the demand. It is estimated that more than 40 percent of the total population of the country lack basic health services or receive only occasional and insufficient services. A large part of the services are only available in the capital; some, in the larger communities in the rural areas; and very few, in the small localities. There are no effective mechanisms for coordinating public health and social security, military, and private sector institutions. The emphasis on intramural care of the sick and the lack of a referral system are other factors limiting the extension of service coverage.

2. Primary health care is provided at the "basic" medical care level in the rural areas and includes elementary services and the use of very simple technologies and auxiliary personnel. It is based on rural clinics, which are established in localities with between 1,000 and 3,500 inhabitants and from which services are extended to the inhabitants of communities with fewer than 1,000 inhabitants through a nursing auxiliary or a "local health promoter." The provision of primary care services at the national level is the basic function of the recently created Basic Health Service. In less than a year this institution has succeeded in establishing this type of care in about 2,000 scattered communities in three out of five health regions into which the country is divided. The most appropriate approach to adopt in developing the strategy of community participation in the process of coverage extension is under study. For the time being, this participation takes the form of the recently established community health committees and the activities for which health promoters have been trained.

3. In order to accelerate the process of the extension of health service coverage, three specific programs have been launched and are being conducted in parallel with the regular programs of the Secretariat of Health: the regionalization program, through which efforts are being made to make each of the health regions self-sufficient in satisfying the basic health needs of the population within their jurisdiction; the program of institutional development, which provides for an administrative reform that will enable the present constraints limiting coordination of efforts to be overcome and will make for rationality in the distribution of resources, better use of them and effectiveness and efficiency of the services; the
program of basic health services, which is being carried out in rural communities with fewer than 2,000 inhabitants. This last-mentioned program is establishing the first link of a referral system that will connect the five medical care levels planned, namely the rural, local, area, regional, and university levels. The principal activities of the regionalization plan are development of the administrative process in each one of the regions and in all its aspects, particularly programming; training of personnel at all levels; installation of referral, information, supervision, evaluation, and cost systems; and regional incorporation of primary health care activities included in the basic health service program.

4. One of the drawbacks of the technical cooperation provided by international agencies under multilateral and bilateral agreements has been that in many cases it tends to transfer organizational models whose adaptation to the conditions in the country is expensive and in some cases unsatisfactory. It is recommended that by multilateral or bilateral agreements the countries themselves determine the type of technical cooperation they consider necessary for supplementing their own efforts in well defined fields.

The establishment of a regional documentation, information and dissemination network to facilitate regular interchange of information between the countries of the Hemisphere and to enable them to share experiences and skills on the basis of formal programs of interchange and cooperation is desirable.
1. The Ministry of Public Health is the directing and coordinating agency of the health activities being carried out in the country. This recently established ministry formulated and is implementing the Five-Year Health Plan (1973-1977), which for the first time embodies as a general health policy the principle that the State should assume increasing responsibility for the protection, promotion, and restoration of the health of the inhabitants of the country, through the provision of services accessible to the entire community, without exception, on a continuing and comprehensive basis.

The service system of the Ministry operates in coordination with the health services of the Social Security System, the Charitable Board of Guayaquil, the Armed Forces, the municipalities, and other institutions of the sector. The scope and potentiality of the traditional community system of health services is not fully known; however, its importance is recognized. In recent years, the process of extension of health service coverage has been systematized through the execution of the Rural Medicine Plan, which includes the establishment of a network of services of increasing extent and depth. This has made it possible to make services accessible to localities with more than 1,500 inhabitants. In localities with fewer than 1,500 inhabitants, i.e., basically the scattered rural population, lack of coverage is due to both geographical and cultural isolation. Furthermore, because of accelerated urbanization the delivery of comprehensive services to an increasing shantytown population is not keeping pace with the demand.

2. Primary health care and community participation are viewed and implemented as basic strategies for extending health service coverage. Primary health care is provided by midwives and nurses in institutions at the first care level and by agents of the informal community system who have traditionally provided health care and have been trained and are supervised by personnel of the institutional system.

Community participation in activities for individual and collective improvement in all development fields has been a traditional feature of the population of the country, which still maintains its vitality and translates it into practice when it is suitably motivated. The capacitation of the community to participate effectively in the conduct of activities designed to meet basic health needs, both individual and collective, is a long-term program based on the organization of the community and on the findings of multidisciplinary research on sociocultural aspects related to health as well as on evaluations of the contents and methods of health education programs.

3. Because of the complexity of the psychobiological, geographical, environmental, social, cultural, and economic problems that affect the rapid extension of health
service coverage, new strategies must be designed and adopted in the institutional service and manpower training systems and in the social communication subsystem. The strategies in the service area primarily concern the rationalization of the administrative process at all levels, the strengthening and consolidation of the strategy of primary health care and community participation and the coordination of the formal and the informal systems, better knowledge of the resources provided by the traditional community system, and the establishment and consolidation of effective mechanisms for intra- and intersectoral coordination of health and related services. As regards human resources, the general strategy is aimed at the education and training of personnel in accordance with the needs of the Second Five-Year Health Plan and is geared to the priority problems identified and the programs designed to solve them; the most appropriate distribution of professional and technical personnel; the establishment of continuing education programs; the strengthening of institutions for training nursing auxiliaries; the programming of the training and development of the human resources of the Rural Social Insurance with which it will put the Rural Health Plan into effect. The strategies mentioned will have to be supported and supplemented by social communication activities: health education, ongoing capacity, and information of the community, which will ensure its conscious and effective participation in all stages of the process of demand for and delivery of primary health care services.

4. International technical cooperation and technical cooperation among countries with common problems and at similar levels of development has been very beneficial and in the future is expected to be of great use in the following principal fields: programmed interchange of experiences and of advisory services of personnel specializing in strategies and methods for the extension of coverage, and advisory services and support to national research programs on appropriate technologies for primary health care; social communication mechanisms and models and techniques of folk medicine in the countries of the Andean Region; methods for the education and training of human resources; and evaluation of the strategies and methods used in the national health service extension process.
1. The Political Constitution of the Republic states that it is the responsibility of the State to protect the physical, mental and moral health of all its inhabitants. The activities for which the health sector is responsible are carried out primarily by institutions of the Ministry of Public Health and Social Welfare and by those of the medical branch of the Salvadorean Social Security Institute. A number of institutions that come under the authority of other ministries, or of parastate and private agencies, provide health services to specific groups of the population or undertake environmental activities in such areas as basic sanitation, water supply, sewerage systems, disposal and treatment of solid waste, housing, and the like. The National Health Committee, of which the Minister of Health is the chairman, is responsible for coordinating the activities of these institutions with one another and with the related activities of other development sectors. The principal health objective of the Economic and Social Development Plan, 1970-1982, is the continuing extension of service coverage, primarily for the purpose of satisfying the basic needs of families in the communities. During the decade, 83.5 per cent of the municipalities in the country have been provided with permanent health posts manned by appropriately trained nursing auxiliaries. Where it has not been possible to establish a health post, health activities are carried out by a "rural health aide," who is a member of the community he serves but is also a member of the regular staff of the institution and is trained to collaborate with the community in preventing diseases, providing first aid, distributing drugs, supervising and training volunteer health groups of the community and orienting its members in making better use of the institutional services available to them.

2. Because of the limitations the country faces in achieving effective universal health service coverage, it has been necessary to organize institutional resources at five care levels: (a) at the community local level, for which a rural health aide is responsible; (b) in a health post, manned by a nursing auxiliary; (c) in a health unit, staffed by a graduate nurse and/or general physician and dentist; (d) in health centers and general hospitals; and (e) in specialized hospitals. This organization is supported by a two-way referral system that ensures that all have access to the level of care required for each case. The first three levels could be considered primary care levels, especially the first level, which is the portal of entry to the institutional system and the link with the community system.

Community participation is being enlisted through the program of the Community Development Department, which comes under the authority of the Ministry of the Interior. In the health field, it is primarily reflected in programs for improving the nutritional status of the population and basic sanitation works.
3. The State plans to focus its strategies on the education and capacitation of the community; the organization of primary health care; the education and training of human resources in accordance with the needs of the system; the most effective use of the present infrastructure; and the allocation of increased financial resources.
1. The provision of health services is the responsibility of the Ministry of Health and Housing which determines policy and formulates programs. Health services to the population of Grenada, Carriacou, and Petit Martinique islands are provided through ten health districts and seven zones in which there are six hospitals, four health centers, and 27 visiting stations. Patient care at scheduled clinics, health centers, and visiting stations is free of charge. Geographical accessibility to services is reasonably good and when the present problems of organization and lack of resources are overcome, other desirable aspects of health coverage will be available.

2. Primary health care is given by nurse-midwives at visiting stations and health centers, under the supervision of a public health nurse or a medical officer. Primary care includes domiciliary midwifery, prenatal care of expectant mothers; child welfare, including food supplementation; first aid and simple treatments; certain immunizations; and guided supervision of certain types of patients.

Community participation is considered important for the development, improvement, and maintenance of health coverage. A health education program designed to secure the active and effective participation of the community in health activities at the local level is being carried out.

3. The Ministry of Health and Housing is particularly interested in strengthening training programs for the development of human resources that will serve at the local level. The Nursing School was reopened in 1977; the training of nursing and dental assistants is likely to start in the near future (dental assistants are now being trained in Trinidad and Tobago), and if a proposal now being studied is accepted, the training of public health aides will begin next year.

Emphasis is being placed on the rationalization and improvement of administrative processes at all levels, particularly in hospitals. New strategies have been designed to overcome the present lack of basic material resources and to adapt health technology to the needs of the community without lowering standards. Special efforts are being made to upgrade diagnostic and treatment facilities and to develop an adequate system of hospital records. Reformulation of the material and child health program, including the retraining of MCH staff and the development of postnatal clinics, is being planned.
GUATEMALA

(Summary of the Report Presented)

1. The State is responsible for the health and welfare of all the inhabitants of the country. That responsibility is vested in its institutions, official and semiofficial and social security agencies, and fulfilled through the execution of the National Development Plan into which the National Health Plan 1975-1979 has been integrated. The Ministry of Public Health and Social Welfare is the directing and coordinating agency of the programs and activities included in the Plan, the overall goal of which is to achieve total health service coverage of the best possible quality for all the population. To that end it is accelerating the coverage extension process (special attention being given to the population of rural and urban marginal areas) and is systematizing the strategies of primary health care and community participation in order to make their application effective and efficient.

The Guatemalan Social Security Institute provides health, occupational disease, accident and maternity coverage for only a small segment of the insured population.

Despite the considerable efforts made, there is still a large percentage of the population that does not have physical, cultural or financial access to the institutional system of health services. Approximately four million persons or 64 per cent of the total population are scattered in more than 9,000 communities with fewer than 10,000 inhabitants. The health problems of those communities vary greatly and have been tackled by institutions using a variety of approaches, the result being uncoordinated programs and activities whose results it has not been possible to evaluate. A sizable segment of the population, a high percentage of which are Indians, use the traditional medical care systems that are deeply rooted in the tradition and culture of the rural and some urban communities.

2. At this stage in the social and economic development of the country, the fundamental strategy being applied or strengthened is that of primary care, understood as the first step towards the satisfaction of the basic needs of the community. The basic elements for ensuring the success of this strategy are: participation of the community, which is to be organized on the basis of its traditions and gradually capacitated to enable it to participate in comprehensive social development, including health activities on an active, conscious, responsible, deliberate, organized, and sustained basis; the reorganization of the institutional system for the delivery of services on the basis of the principles of integration, functional regionalization and effectively interconnected care levels so as to ensure the most appropriate care for all at the proper time; the establishment of effective interinstitutional coordination mechanisms within the health sector and their articulation with the traditional community system; and, finally, use
of a multisectoral approach in dealing with health problems, which will be addressed through coordinated intersectoral activities, especially at the local level, closely articulated with the intermediate and central governmental levels.

3. For the purpose of accelerating the extension of health service coverage, the following activities are planned:

- Establishment of a well-defined health policy that will serve as a frame of reference for dealing with health problems and the strategies that have to be applied; clear definition of the objectives and goals or priority programs for dealing with the basic needs of the communities and, consequently, selection and adaptation of existing technologies and creation or adoption of new technologies that will ensure the viability, effectiveness, and efficiency of the program;
- Improvement of the organization and operation of care levels;
- Strengthening of the regionalization of services, which entails better and more rational distribution of human, material, and financial resources;
- Upgrading of the operational capacity of the general administrative process, in particular, at the local level, of linkages with the community, where the simplification and flexibility of the process is essential;
- Special attention to the development of information systems through a continuing process of analysis and interpretation for decision-making, which will permit the evaluation and programming and budgeting of health sector activities;
- Promotion and encouragement of operational research at all levels, and thus the adoption and adaptation of new technologies and the enhancement of the quality and effectiveness of the services delivered to the community.

4. The most important external technical cooperation areas for supplementing national efforts are direct support through personnel with experience in coverage extension programs and the education and training of personnel, both locally and abroad. External financial assistance, especially for intensive programs for the recuperation of installed capacity, extension of the network of local services, and basic sanitation, is also useful.
1. The Government of Guyana is committed to the task of achieving a better life for all the citizens. Within its financial limitations, it accepts responsibility for the provision of basic health services of high quality to all its citizens; an equitable distribution of health services throughout the country; and the solution of problems that are beyond the capacity of the individual, such as food and drug control and industrial hazards.

The National Health Plan 1971–1980, now under way, was based on that policy. Health services are provided by the institutional system, which comprises government hospitals, health centers, health stations and medical outposts; health facilities of the nationalized bauxite and sugar industries; and the private sector. The traditional community system refers to the indigenous practice of using the services of traditional healers and local medicines, mainly herbs. Little, if any, communication exists between the two systems.

In 1975 levels of health care were defined and the category of personnel at each level was determined; the various levels of care were then related to specific populations and health regions were established. Training of personnel and distribution of all resources were planned accordingly.

No statistics of actual health coverage are available but it is recognized that there are significant groups of people in the rural hinterland and riverine areas where health services are insufficient or not available. Among the factors contributing to that situation are the following: an estimated 27 per cent of the total population lives in localities with fewer than 2,000 inhabitants; there are 1,321 localities, each with fewer than 500 inhabitants; communication is difficult and expensive; weaknesses in the organizational and administrative structure that hinder decentralization; shortcomings in planning and programming previous to program implementation; inequity in the allocation of the country's health resources; weak intrasectoral and intersectoral coordination; failure of manpower policies to keep pace with the country's health needs and resources; increasing capital costs of physical facilities and equipment; weakness in the management information system; and lack of reliable data for decision-making and for providing scientific basis for change.

2. A change in health policy is necessary if the rural areas in particular are to receive a fair share of the country's health resources and the rural communities are to be covered by integrated primary health care programs. Primary health care may be defined as the first point of contact with the health care delivery system. Whereas in the urban setting this care may be provided by a medical practitioner, in rural areas it is provided by a variety of personnel, e.g., community health workers, sick-nurse and dispenser, and staff nurse-midwife. In
urban areas, care is given at the doctor's office or clinic; in rural areas, at medical outposts, health stations or health centers.

Through regionalization, cooperatives and health education programs are being organized so that informed decisions may be taken after consultation with the community and more active community participation in project implementation may be enlisted. A study has been made of the manpower available and the tasks it performs with a view to possible regrouping of functions or introduction of new categories of personnel. The most significant measure being taken by the Ministry of Health, Housing and Labor, to relieve the manpower shortage and to extend coverage at a cost the country can afford is the training of paramedical personnel. These middle-level practitioners train community health workers and thus produce a multiplier effect.

3. In developing the national strategy for the extension of health coverage, major emphasis was placed on a revision of health manpower policy and health care system. It was decided to make full use of auxiliary and middle-level personnel. The community health workers will be the frontline workers of the system and will also be responsible for coordination and communication with the traditional system. Major elements of the strategy for improving the health care system are: definition and establishment of rational levels of care and an operative referral system; strengthening of functional regionalization; integration of health services; emphasis on ambulatory care; and external financing for capital investment. A proposal to introduce a National Health Insurance Scheme financed by individual contributions for medical care, hospitalization and maternity care has been confirmed. It is in keeping with the national philosophy and has the political support of the highest level.

4. Guyana would appreciate technical cooperation from international agencies as well as from individual countries in the areas of (1) interchange of information on successful technology in extending coverage, and (2) training in administration, maintenance of equipment and of tutors. Guyana can provide places for trainees in its pharmacy, medical technology, dental nursing, and paramedical programs and can also provide information on legislation governing the practice of auxiliary personnel.
HAITI

(Summary of the Report Presented)

1. Health service coverage of the entire population of the country is the principal goal of the 1975 Health Plan that is being implemented by the Secretariat of State for Public Health and Population. The institutional service system, made up of health sector establishments, covers only part of the population, namely that located near the capital and that of the larger communities. The remainder of the population, which is the great majority of it, has traditionally made use of the community service system, the existence of which is known through the activities of its agents: mid-wives, injectors, herbalists, bone setters, and medicine men.

Under present conditions it would not be feasible for the institutional system alone to provide total coverage. It will be necessary to adopt new strategies leading to a better and more productive use of existing resources, the development of new resources, the development of human resources and technologies, and the coordination of the efforts of all the socioeconomic development sectors of the country.

2. It is recognized that health is influenced not only by the services provided by the health system but also by the services of other institutions in the fields of nutrition, education, housing, sanitation, employment, and recreation. This multisectoral approach to health problems would be the essence of the primary health care strategy. Its application would have to be accepted and supported by the community itself. This means that a thorough knowledge of the social dynamics and the mechanisms of the traditional community system are required in order to explore the possibilities of establishing efficient and effective links with the formal institutional system.

Programs are under way for the construction and rehabilitation of health establishments that will provide service coverage in the northern and southern regions of the country, where the strategies of primary care and community participation are being systematically put into practice. The results will be promptly evaluated and the necessary adjustments made in order to determine the criteria, scope and standards of primary health care in Haiti as well as the methods of applying it on a national scale.

Among the negative factors affecting the coverage extension process are: administrative problems and the lack of human resources trained in administration; general shortage of trained personnel, which is worsened by difficult working conditions and unattractive salaries and allowances; lack of transportation and of overland communications; lack of appropriate health technologies; and costly dependence on imported technologies which are not always the most suited to the needs and possibilities of the country.

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3. The Secretariat of State for Public Health and Population has begun to implement a plan which provides for six health regions, each comprising two or three districts, with services organized at five care levels. They are functionally coordinated by means of a responsive administrative process that will facilitate the operation of information, logistics, supervision, patient referral, and evaluation systems. Studies on the dynamics and contents of the traditional community system will be continued, and pilot projects will be undertaken to determine which mechanisms would be the most suitable for coordinating it with the institutional system and what would be the advantage of this operation and its impact on services coverage. A manpower development policy will be established and directed towards: strengthening and rationalization of the present programs for the education and training of new staff at the first service levels, and promotion of the reform of the professional and technical training curricula of the institutes teaching health sciences and methods. Finally, a policy for the control of the transfer of technology, which involves bilateral and multilateral technical cooperation and credit agreements, will be defined.

4. There are two fields in which technical cooperation is of special interest to the country: the education and training of personnel in the application of the strategies of primary care and community participation; and development of the administrative process, especially managerial and evaluation aspects. The continuation and promotion of the interchange of experiences and of human resources between countries with similar problems is exceedingly important.
HONDURAS

(Summary of the Report Presented)

1. Since 1973 organized efforts have been under way in the country for the extension of health service coverage. The reason for these efforts was the fact that 55 per cent of the total population was for some reason or other outside the institutional health service system.

Health policy with respect to coverage is being based on a better knowledge of health problems, of the ecobiological, social, cultural, and economic determinants of health and of its relations with the social system for supplying services. This policy is embodied in the National Health Plan, which is an integral part of the overall National Development Plan; it is primarily designed to satisfy the basic needs of the marginal communities, chiefly in the rural marginal areas; to support primary care services; and to enlist the active participation of the community, which is deemed essential; and to use a multisectoral approach for the solution of health problems.

2. Primary health care does not mean an additional level in the scale of complexity of medical care; it is essentially an element that potentiates health resources; promotes and stimulates the capacitation and organization of the community with a view to its participation in improving its health and welfare; rationalizes the flow of patients and of community problems to the institutions that provide services of higher complexity; and generates effective mechanisms for linking the traditional community system with the institutional system. In the rural areas, primary care services are provided by rural health centers, each manned by a nursing auxiliary and by a promoter who is responsible for basic sanitation activities.

The health centers receive technical and logistic support from the higher institutions of the system and these activities are extended to the communities through "representatives" or "health guardians" selected by the community itself and by lay midwives that have been trained. Continuing training programs are provided for these agents in order to enable them to undertake the activities the community itself indicates. The capacitating participation of members of the community facilitates discussion and coordination between the two health service systems, the institutional and the community, and ensures that that participation is effective in all stages of the process and not only in that of program execution.

3. So far, the process has been proceeding as planned. However, obstacles have been encountered and are slowing it down but not halting it; the most important of these are those relating to the referral system. The unsatisfactory operation of the system is a cause of frustration for local health workers and of injustice and skepticism for patients. Furthermore, the referral system is a mechanism by means of which the right to health services satisfying their basic psychobiological
needs is guaranteed to all. Another limiting factor is the logistic shortcomings that affect the production and delivery of services at the local level. These administrative constraints are worsened by the shortage of trained manpower and limited financial resources whose increase does not keep pace with the increase in the demand for services. Extension of coverage based on the above-mentioned strategies is considered a long-term process which generates constant changes both in methods of work and in the attitudes of the persons that take part in it, particularly of those at the higher decision-making levels. If this process is to be productive, it also requires a high level of institutional coordination and solidarity both within the health sector and with other development sectors.

4. The Ministry of Public Health and Social Welfare is of the opinion that technical cooperation between the countries and by international organizations is extremely important in the field of exchange of information on experiences and know-how and techniques of programming, administrative development, education and training of human resources, design of investment projects and other projects of common interest dealing with strategies for accelerating the process of extending health services to the population of urban and rural marginal areas.
JAMAICA

(Summary of the Report Presented)

1. The Ministry of Health and Environmental Control has produced a health policy document which states that health is a fundamental human right and not the privilege of a few, and that it is the responsibility of the Government to ensure that this right is enjoyed by all. The present population of Jamaica is estimated at just over two million people, 58.6 per cent of whom live in small communities in rural areas.

The government is the main provider of health care. The private sector provides facilities for a small segment of the population. It is recognized that health coverage leaves much to be desired. From the functional standpoint primary health care services are not fully accessible in that many are provided on an intermittent basis only and most are unable adequately to meet all the demands of the community.

The health policy document also states that health is dependent on other social and economic programs such as full employment, equitable distribution of wealth, education, housing, cultural, sporting, and recreational facilities. The health planning process therefore involves such agencies as the Ministry of Local Government, which is responsible for the delivery of many primary care health services, and the Ministries of Education, Youth, Social Development and Sport, and of Agriculture. The National Planning Agency is responsible for coordinating the plans and programs of all the individual agencies. Furthermore, health care is provided in close association with other social services, and health aspects are taken into account in programs of industrial, agricultural, and economic development.

2. Primary health care in Jamaica includes all the services provided at the community level. The intention is that these services should be shaped by the lifestyle of the community and provided by multidisciplinary health teams whose training is relevant to the needs of the people. With such a team approach, all health workers become partners and have an understanding of each other’s role.

Full participation of the people in all sectors and at all levels of the national life is encouraged. Health committees are being formed in association with community councils. These committees are encouraged to identify health needs and to take an active part in meeting them. They are also being helped to become health educators in the community. The use of mass media in the health education of the community and in enlisting its active participation in ongoing health programs is being explored.

For some years now, a new category of worker, the Community Health Aide, has been at work at the community level. She works in the community in which she lives. Initially, she receives six weeks’ training so that at first the scope of her work is limited, but continuous on-the-job training from other health staff
gradually increases her usefulness. An additional category, the nurse-practitioner, is being trained. This training will enable her to reduce the work load of the medical officer, and more people will thus have access to the higher levels of primary health care.

3. Progress towards the achievement of total coverage with primary health care services must be supported by community involvement. Health workers will be encouraged to think of themselves as a team working in and with the community and through a continuing program of in-service training to update and upgrade the skills of all health staff; each task will be performed by the least trained health worker capable of carrying it out and acceptable norms and procedures will be applied.

Administratively, integration of curative and preventive services, regionalization and decentralization of the decision-making process are being implemented, starting from pilot projects in selected regions where problems inherent in integration and decentralization can be identified and resolved in close proximity to the field. An extensive educational and training program, including administrative as well as field staff, is required, as is revision of priorities in financial allocations.

4. The main program areas for technical cooperation from international organizations and between countries would be: health planning, manpower development, management, health education, health information systems, the building of health centers, and the supply of equipment. These all relate to the extension of health coverage within primary health care and will make for increased community participation.
1. The Secretariat of Health and Welfare, the Mexican Institute of Social Security, and the Institute of Security and Social Services for State Employees are the most important agencies of the public sector providing comprehensive health services to the population. The first mentioned is legally responsible for the public of the country and the other two provide services to specified population groups. Their institutions, which are distributed throughout the country, provide services of varying degrees of complexity and cover about 97 per cent of the urban population and 7 per cent of the rural population (communities with fewer than 2,500 inhabitants). It is estimated that 38 per cent of the population (approximately 24.5 million inhabitants) are unserved or have insufficient services to satisfy their basic needs, especially in the rural areas.

Among the factors affecting the limited coverage of rural communities are: dispersion of the communities (more than 25 million persons live in 94,410 communities with fewer than 2,500 inhabitants, and of these more than 11 million live in 83,705 communities with fewer than 500 inhabitants); rugged topography, which makes road communication difficult; low level of functional literacy and of economic and social development; and in general, a high rate of population increase (3.8 per cent). Furthermore, strong rural/urban migratory movements are responsible for the increase in the urban population (from 58 per cent in 1970 to 61 per cent in 1977). The settlement of this population in periurban and urban shantytowns has generated an increasing demand for services which the installed capacity of the institutional system is unable to satisfy.

2. Primary care and community participation are strategies deeply rooted in the history of the country and are linked to the development of health services there. The establishment of the Cooperative Rural Medical Services of the Secretariat of Health and Welfare, the Cultural Missions, and the National Indian Institute of the Secretariat of Public Education and, recently, the Social Solidarity Programs of the Mexican Social Security Institute are modern examples of the efforts made to apply these strategies with a multisectoral approach to the health problems of the rural areas. However, because of lack of continuity and support, many of these efforts have not been institutionalized at the national level; nevertheless, they have left a store of experience that can be put to good use.

3. As fundamental policies of the health sector, the Government has designated the universal extension of coverage with equality of opportunity and as an instrument for the equitable distribution of social justice; recuperation of installed capacity; development, training and capacitation of human resources; installation of service units in rural localities that lack regular services; health educa-
tion and capacitation of the community for participation; strengthening of health establishments located in urban areas; strengthening of intra- and intersectoral coordination mechanisms; regionalization of the delivery of services by levels of complexity interconnected by two-way referral and information systems and by an efficient system of advisory services, supervision, control and technical support; redistribution of resources (redefinition of the functions of the existing human resources, review for the creation or selection of appropriate technologies, streamlining of administrative and logistic processes, and reallocation of financial resources, all on the basis of the identification of the principal health needs of the rural areas and of the urban marginal areas).

The existence of a traditional community system for solving health and maternity problems is recognized. It is planned to evaluate local resources, knowledge and traditions, in order to make use of those that are favorable and to strengthen them through a training program, especially in localities with fewer than 500 inhabitants. It will be coordinated with the institutional system through the first service delivery level of the regionalized formal system.

4. As areas of international cooperation and of cooperation between two or more countries, the following are mentioned: exchange of information, experiences and technology; scientific research applied to priority fields of the coverage extension process and its strategies; and participation of international personnel in the evaluation of the process.
NICARAGUA

(Summary of the Report Presented)

1. The National Economic and Social Development Plan assigns high priority to the development of health services, especially those for the rural areas of the country. The institutional health service system comprises the Ministry of Public Health, the National Social Assistance and Welfare Board, the Local Social Assistance Boards, the Medical Services of the National Guard, and the private subsector. In Nicaragua, the system has traditionally concentrated services in the urban communities, while the rural communities are covered by vertical programs, most of them on an occasional or sporadic basis. The present scope of service coverage in the country is not known, but is assumed to be relatively high for the urban population and to cover only 25 per cent of the rural population. Since the 1972 earthquake, the national health policy has given priority to programs designed to satisfy all the basic needs of the rural population, and to enlist community participation for that purpose.

2. Primary health care is defined as the set of services provided at the first care level of the institutional system. Its operational center is the health post manned by a nursing auxiliary assisted by volunteers from the community itself. The health posts are located in communities with fewer than 2,000 inhabitants and operate under the technical supervision and with the logistic support of a health center at the second care level, where full-time medical professional personnel and nursing personnel are available. A number of programs are being executed in rural areas in which community participation is the driving force and in which institutions of other ministries are involved. Health programs which assign particular attention to the education and capacitation of the community in the fields of basic sanitation, food and nutrition, and rural development are contributing to the multisectoral effort of community organization for development.

3. The intensity and rapidity of the process for the extension of health service coverage is affected by the lack of resources and by administrative factors. These limitations are being overcome. The National Public Health Council, the directing and coordinating agency of all health activities in the country, has formulated a program with the following principal objectives to be attained in 1982:

- Strengthening of mechanisms for interinstitutional coordination and promotion of intersectoral coordination.
- Strengthening of the system for the regionalization of health services based on the effective operation of the five care levels established.
- Strengthening of the mechanisms for ensuring proper operation of the referral system.
- Reorganization of the supervision and information systems.
• Streamlining of programs for the education and training of personnel in accordance with the requirements of the coverage process.
• Construction, equipping and operation of facilities at the local, intermediate, and central levels, so as to guarantee the service coverage of just over one million persons representing 76 per cent of the total rural population.

4. Technical cooperation between countries and by international organizations would be appropriate in the following principal fields: epidemiological surveillance; regular interchange of information, technology and skills relating to strategies of primary health care and community participation in the extension of coverage; cooperation for the production or procurement of low-cost biological products for the prevention of diseases; external credit facilities for the production of goods and services for social development; strengthening of cooperation in the field of education; and training of personnel within the country.
1. Health is considered both a right and a duty and should be the same for all the inhabitants of the country. This data is the essence of the law which in 1969 established the present Ministry of Health, the overall goal of which is the extension of health service coverage to the entire population. The process for achieving that goal has been under way since that time and is aimed at: the formulation of health policies in the context of the national overall development plans and policies; the establishment of a regionalized health system with integrated services organized at stepped levels of care interrelated by a referral system; and the organization and capacitation of the community so that it can effectively participate in the system.

   Health policy is based on the principle of equitable distribution of resources in accordance with the priority needs of the communities and serves to support: integration of health programs into the activities of organized communities; the promotion of community organization; education and training of multipurpose health workers in the communities themselves; reorganization and improvement of the institutional service system with a view to the establishment of a unified national system; and the acceleration of the process of extending coverage to the inhabitants of rural and urban marginal areas.

   Because of the high degree of dispersion of the population in rural areas (50 per cent of the population lives in rural areas; of a total of 9,313 localities in the country, 9,024 have fewer than 500 inhabitants) and the growing problems of urbanization, it is necessary to adopt new strategies and to strengthen the efforts under way to coordinate institutions providing health services with one another and with institutions of other social and economic sectors.

2. In order to achieve universal coverage, activities have been undertaken with the smallest communities to enable them to establish primary care services. These services include comprehensive health care of individuals (protection against preventable diseases, perinatal and maternal care, first aid for accidents and acute diseases and referral of patients to institutions that can provide the service they need), environmental activities (basic sanitation, water supply and waste disposal), and promotion of food production. These activities require the collaboration of other disciplines. Multipurpose and multidisciplinary teams have been formed and, in the communities, are setting in motion a process of capacitating participation based on in-service training and continuing education.

   The principal factor for the application of the strategy is the "medical assistant" who is a member of the community he is going to serve and who is given systematic training and supported by technical and professional personnel of the institutions providing more complex care. Regular evaluations of these
workers make it possible to introduce adjustments and to sustain a process of continuing training.

The new Political Constitution consolidates and enlarges the concept and content of community participation, enlists it in the solution of the problems of development, and guarantees an equitable distribution of its benefits. The problems are analyzed by community "boards" which operate at the local, municipal, district, provincial, and national levels and on which the health sector is represented.

3. The conceptual and legal bases for the extension of health service coverage have been established, and strategies for accelerating the process have been defined. In the next few years efforts will be directed towards strengthening the organization and functional integration of state, parastate, autonomous, and semi-autonomous health institutions, as prescribed by the Constitution and, consequently, towards improving the regionalization system and the coordinated and efficient operation of the stepped care levels. Activities for the training of paramedical personnel, in particular medical assistants, will be continued, as will be those for strengthening the supervision and continuing training systems. Special emphasis will be given to improving administrative aspects, both in general and as regards their support functions, through a program for the training of administration personnel at all levels. This program has already been initiated.

In the next three years the administration process is expected to be better able to respond to the needs of the national health system and to universal service coverage.
PARAGUAY

(Summary of the Report Presented)

1. Health is considered a human right without limitations and without restrictions which must be guaranteed to all the population through regular services and with the responsible participation of the community. These services are provided by public, mixed and private institutions. The Ministry of Public Health and Social Welfare is the directing and coordination agency of the activities of the health sector. The National Health Plan, 1976–1980, is in operation, and its primary objective is the extension of service coverage, especially to the population of rural areas and to the most vulnerable groups.

“Covered population” is defined as that population which receives at least minimum health services (primary care) on a continuing basis and has access to any of the care levels of the National Health System. A recent study showed that that population represented approximately 77 per cent of the total; 79 per cent of this coverage is provided by the Ministry of Health and the remaining 21 per cent, by Social Security, Military and Police Force Medical Services, the National University, and the private sector.

The non-covered population is scattered in small rural communities and in urban and peri-urban shantytowns. The multisectoral approach to health problems, the slow but steady increase in health resources, their better distribution and the improvement and consolidation of the strategies of primary care and community participation will continue to accelerate the coverage extension process.

2. Primary health care is provided at the first of the four care levels included in the institutional health service system. Primary care means that resulting from the delivery of minimum or simplified health services, both those given directly to individuals as well as simple basic sanitation activities. These services are the responsibility of auxiliary personnel who have been specially trained and who man health posts in the “companies” that are far removed from a health center, which is the second care level.

Community participation takes the form of cooperation in the construction of health centers and posts, “pledges,” and, in some places, of regular volunteers who provide services.

These strategies are backed by a broadly-based program for the education and training of auxiliary and volunteer personnel as well as for the health education of the entire community. Furthermore, studies are being made to ascertain the quality and scope of the traditional community service system in the light of sociocultural patterns, resources, and favorable or unfavorable impact on the satisfaction of the felt needs of the community. Efforts are being made to strengthen the infrastructure of the first care level without neglecting that
generated by the traditional community system, which is an asset and a potential force of incalculable value in Paraguay.

3. The ongoing evaluation of the programs, methods and strategies of the National Health Plan will make it possible to promptly introduce the necessary adaptations and amendments for ensuring the efficient operation of the system of regionalization and care levels; the efficiency of the referral system; the continuing recuperation and improvement of the installed capacity of the institutional health system; and the strengthening of intra-sectoral coordination mechanisms for their coordination with other socioeconomic development sectors.

Special attention will continue to be given to activities for the training of auxiliary personnel in rural nursing and midwifery for health posts and new services in rural areas remote from health centers. The Center for the Training of Professionals has been established and will produce technical personnel for the services of the second and third care levels, and a national program for training technical personnel at all levels will be undertaken.

Studies and evaluations will continue to be made for the purpose of giving final form to strategies for the strengthening of community participation in all stages of the process of its comprehensive development, including health development.

4. For the purpose of accelerating the process of health service coverage as outlined above, external cooperation has been available for supplementing national resources for financing works for the expansion and improvement of the infrastructures in high priority regions (Alto Parana) and in the areas of the integrated rural development projects. International cooperation and cooperation between countries will be very useful in the fields of education and training of human resources and in the selection and application of techniques for improving the efficiency and effectiveness of administrative processes of the extension of coverage based on the strategies of primary health care and community participation.
1. The health status of the Peruvian population is unsatisfactory. The risks of falling sick and dying are very high and are characteristic of an undeveloped society in which the standard of living is low. This high mortality is largely due to diseases that can be prevented or reduced by the application of well known health techniques. A variety of health institutions are involved; health resources are limited and badly distributed, and their production and productivity is low; and health manpower training is inadequate. Health planning is based on the resources available and not on the actual needs of the population.

2. A reorganization of the health services consistent with the major transformations Peruvian society is undergoing has been proposed and will make it possible to move ahead with the formation of the new Peruvian man whose profile has already been defined (General Law on Education).

Health is acknowledged to be the inalienable right of all the inhabitants of the national territory, not only to receive care but also to take an active part in the programming and execution of health activities that will benefit both individuals and the community.

Efforts are being made to banish the focalist concept of health, which centers attention on existing disease, almost completely ignores its multiple causative factors, and involves little or no participation by the members of the community who are thus mere passive recipients of health services. The elitist concept of health, which has transformed its problems, even the simplest problems, into complicated facts that can be tackled only by a group of experts from which all others are excluded, is to be eliminated. The highly sophisticated technocrat criteria, which result in a large part of the Peruvian population being deprived of health care, are to be abandoned. Finally, health is to be rescued from the harsh grip of supply and demand, which has made it into a matter of profit and commerce and put it outside the reach of the great mass of the population.

This model of universal and participatory care demands a change in the attitude of the population which at the same time helps that change to come about. Consequently, it demands a radical change in the overall health policy, a new vision of the role of technology and of its proper place in a dependent country struggling against underdevelopment.

3. In short, the plan is to create a health care model that has an authentic national basis. One of the strategies proposed is primary health care and community participation, understood as the set of planned comprehensive health activities which are carried out at the first care level of the system (households and communities) in order to provide individuals and the community with a satisfactory
level of health and in which participation will be a continuing process of direct, conscious, responsible, and organized intervention by the community in the taking of decisions aimed at satisfying its health needs and achieving integrated development.

The frame of reference described above has led Peru to adopt the following strategies:

- To accelerate the process for the extension of health service coverage, priority being given to the population of rural and urban marginal areas, with a view to achieving comprehensive, universal, effective and efficient care.
- To integrate the various health institutions, both private and public, into a national, regionalized, stepped, and participatory system.
- To accelerate the enactment of the General Health Law as an instrument of doctrine and policy.
- To accelerate the process of deconcentration and regionalization of health services and to coordinate them with those of other sectors.
- To plan a clearly defined structure within the national health service system which will channel and develop the participation of the community in accordance with the national model.
- To promote a change of emphasis in the productive effort within the social model, in which the exploitation of natural resources will ensure an increase in wealth and its equitable distribution and thus makes it possible for all Peruvians to have access to the goods that produce health such as food, clothing, housing, education, employment, and recreation.
- To coordinate and articulate the policies and strategies of the health sector with those of other sectors with a view to the achievement of the national development objectives.
- To provide primary care with the legal, administrative, and financial instruments for its execution and development.
- To program and develop primary care activities in the home and in the community and, on the basis of the problems that occur at these levels, to determine the functions and organization of the other levels of the national health service system.
- To develop and train health manpower, gear it to the process of coverage extension, and assign priority to that which will be responsible for primary health care.
- To coordinate the programming of health manpower training with the Peruvian universities in accordance with the priority policies of the sector.
- To conduct scientific research and to develop national technologies that will enable the country to surmount its dependent status.
- To promote research on ethno-medicine and its agents, at the national level, in order to integrate its positive elements into the health technology of the country.
- To strengthen the Basic Drugs Program and to ensure an adequate supply of them, priority being given to rural and urban marginal areas.
- To study and evaluate the extent and depth of the procedures and the effectiveness of each of the national experiences with respect to primary health
care and community participation in order to define national, regional, and local criteria that will enable them to be systematized and further developed.

* To promote the development of the functions and structures of the mass social organizations of the communities that are essential for their intervention in the system and in health care.

4. With respect to PAHO/WHO technical cooperation, it is recommended that the allocation of funds be adjusted to the priorities established by the countries for each program; that technical cooperation be directed towards areas in which national technologies and resources are available for making efficient use of it; that the programming of technical cooperation and the formulation of the corresponding plans of operations ensure full participation of the national personnel responsible for its execution and evaluation; and that special attention be given to the programs provided for in subregional integration agreements as well as in bilateral programs for border cooperation.
1. Suriname became an independent country in November 1975. Its health system is in the process of redesign and development. Although health coverage was good in theory, the accessibility of health care institutions at the beginning of the referral chain was limited in practice. Total health coverage is expected to improve when more human resources and health facilities are available, a ready referral system is working, and transport and communications are better.

2. Over the last few decades, community participation in health care projects along more conventional lines has included primary health care schemes for the small tribal communities scattered along the rivers of Suriname’s hinterland. A government-subsidized missionary foundation has been working in this area with different levels of auxiliary personnel.

3. In March 1977 the Council of Ministers approved a national health care plan as part of its overall development plans. The national health insurance scheme, under which the entire population would receive medical care free of charge, is an essential part of the health plan. The legal framework of the plan was approved by Parliament in May 1977 and preparations for its implementation are being made by a Board of Trustees. All the functional groups concerned, including employers and labor unions, professionals and institutions providing health care, are taking part in these preparations which may be considered an exercise in community participation at the national level.

4. Suriname needs technical cooperation in the following fields: development of administrative infrastructure, epidemiological surveillance and control of communicable diseases, environmental health, development of human resources, and the establishment of supply and maintenance systems. It looks forward to cooperating with countries that have objectives similar or complementary to its own.
TRINIDAD AND TOBAGO

(Summary of the Report Presented)

1. The Ministry of Health and Local Government is responsible for providing health services. Weighting national health care on the side of preventive medicine is now the accepted and enunciated health policy. The expected success of efforts to emphasize preventive medicine at the community level will reduce the number of individuals requiring medical care and, as a consequence, resources will be released and channelled to higher standards of institutional care and the provision of specialized areas of health care, as needed. The health coverage process is being accelerated by the development of community health services and the program for the upgrading and improvement of institutional facilities. The traditional community system does exist, but it is not being identified and there are no mechanisms for articulating it with the institutional system.

2. Primary health care is seen as the simplest form of health care given by a recognized member of the Ministry of Health and Local Government. Primary care is based on health centers and the intersectoral approach is used at the local level. Community participation is encouraged through existing community organizations such as Community Centers and Village Councils. The creation of interest through education extension is considered conducive to community participation. The provision of personnel appropriately trained for use at the rural community level as well as the selection and adaptation of technology to fit local needs and conditions are being stressed, as is the program for development of community health services.

3. Community health services will continue to be developed in accordance with the principles of: regionalization and decentralization of management; interdisciplinary approach to health problems; closer liaison between hospital and district services; integrated family health care, where possible; more effective multipurpose utilization of staff and facilities; cooperation and collaboration among and between Ministries; and lay participation. The importance of health education in supporting all other health programs is fully recognized. A family life education program is being developed and implemented in collaboration with the Ministry of Education. The extension of service hours so as to provide country-wide 24 hour service is seen as another means of extending health coverage and of improving the productivity of health services at all levels.

4. Technical cooperation from international organizations and between countries, especially in the Caribbean, would be useful in the fields of: research and laboratory services programs; bulk purchase of drugs by several countries, reduction in the number of brand-name drugs and consequently a reduction in costs; cooperative development of training facilities, especially at the university level; and interchange of information, knowledge and technology on health matters.
1. It is the national health policy of the United States of America to provide all the citizens with access to high quality health care. The health care system of the country has developed as a product of multiple inputs from the public and private sectors. Federal responsibility is undergoing careful definition, and traditional roles are changing. The enactment of the National Health Planning and Resources Development Act of 1974 and the Health Professions Educational Assistance Act of 1976 represent just one aspect of an intensive national reexamination of the effectiveness of the health care delivery system in the country.

Under the Health Manpower Act professional personnel are recognized to be a national resource, and the Federal Government has agreed to share with the private sector responsibility for assuring that enough qualified personnel are available to meet the health care needs of the nation. The National Health Planning and Resources Development Act deals with the processes by which health services and facilities are developed, maintained, and coordinated. These two pieces of legislation have perhaps established part of the framework for a national health insurance program.

While existing programs have produced significant advances towards the total health coverage goal, a number of problems remain. The Government is particularly concerned about the following: the structure of the health care delivery system, which consists of many individual local and fragmented, private systems; the training and deployment of manpower and the redistribution of other health resources; the quality of care; the definition of standards, and particularly the need for more comprehensive approaches to prevention; and, finally, the financing of health care and cost containment. It is estimated that 49 million Americans reside in medically underserved areas where there is a high proportion of poor and elderly, coupled with few physicians and high infant mortality. Many of these individuals still do not have access to adequate primary care services.

2. One of the country's aims is to emphasize primary health care services. To that end the community structure and professional and non-professional persons in the community will be used to plan for and to deliver the services. The objective is an informed citizenry, fully aware of preventive health practices, the proper utilization of the health services available, their individual roles in maintaining personal and community health, and the limitations inherent in the organized medical care system.

3. The Government has begun to plan for a national health insurance program, taking into account its potential benefits to every citizen, and the safeguards
necessary to prevent cumbersome bureaucracy, uncontrollable costs, and misuse of available services.

The national health insurance program is intended to reform the health delivery system, in addition to assuring financial access to care for all Americans. It must address issues such as redistribution of manpower and services, particularly to ensure that services are available to previously underserved populations; innovations in training, especially in the preparation of primary care practitioners; the need for prevention and health education, with biomedical research increasingly directed at prevention and early detection of disease; rational planning and guidelines for optimum utilization of health facilities, equipment, and technology; and the organization of innovative delivery systems.
URUGUAY

(Summary of the Report Presented)

1. In the country there are some 210 institutions providing health services, primarily medical care services. Approximately 80 percent of these institutions are private institutions and serve about 35 per cent of the population of the country. The remaining 20 per cent, which account for 81.9 per cent of the total beds in the country (13,314 out of 16,251), are institutions of the public sub-sector and the remaining 65 per cent of the population use them to satisfy their medical care needs.

   The Ministry of Public Health is the official agency responsible for guaranteeing the right to health of the entire population. It is responsible for the coordination at the national level of the activities of the health sector, the execution of all programs for disease prevention and health promotion, and the medical and institutional care of certain diseases—some infectious, mental, and chronic diseases—which is not provided by the other institutions of the sector.

   It may be stated that, under these conditions, health service coverage is nationwide and complete. However, it is recognized that, because of administrative shortcomings, there are population groups in certain rural and periurban areas that remain on the fringe of the national medical care system.

   The National Health Plan being implemented was based on a policy that drew its inspiration from a comprehensive concept of health and of health protection, promotion, and restoration activities. It adopts a multisectoral approach to health problems and is aimed at improving the administrative process at all levels, principally in the areas of planning and programming, intra- and intersectoral coordination, and institutional organization and operation.

   There is no traditional community system, since Uruguayan society is culturally and ethnically homogeneous; its values and behavioral patterns are very uniform; and it has good means of communication and transportation.

2. Primary health care is defined as the service given by each member of the health team under any circumstances or in any place, almost always in accordance with the indications of a physician. In the capital of the country primary health care is provided through the out-patient services of public and private institutions and in the interior through the out-patient departments of hospitals, health centers, and the rural policlinics of the Ministry of Health and other official agencies. This is also considered the first care level. To strengthen this primary level an agreement has been made with the Faculty of Medicine for the training of “rural physicians” who will be assigned to places in which their services are needed.

   Because of its ethnic homogeneity and broad access to education, already mentioned, the Uruguay population has traditionally shown interest and co-
Uruguay

operated in community efforts. The authorities have traditionally planned a variety of activities, and the population spontaneously furnishes various types of assistance. During the present Administration, this participation and cooperation has increased considerably, and many activities have been carried out with the direct support of the community or through institutions of the Armed Forces, the municipalities, and the like. The joint and coordinated activities of the Ministries of Public Health and of Education and Culture will contribute to the development, from the school years onwards, of personal and collective attitudes favorable to participation in the national process of improving health conditions.

3. The principal obstacles to or constraints on the improvement of the extension and quality of health service coverage, which should be comprehensive, continuous and efficient, are not so much health problems proper as the administrative problems inherent in the organization and operation of the health system. To overcome these limitations the Ministry of Public Health has initiated a program of activities which focuses on:

- Restructuring and reorganization of the Ministry itself and adjustment and development of executive agencies;
- Regionalization of services and coordination of care levels;
- Updating of legislation, regulations, and standards supporting the coordination and adoption of existing institutions, both public and private;
- Reorganization of collective medical care institutions (health insurance and other social insurance schemes);
- Cooperation and coordination of education, research, and service institutions in the fields of the health sciences;
- Coordination and collaboration between and with the institutions of other socioeconomic development sectors.
1. The National Constitution of 1947 and 1961 stipulated that the health of the individual and of the community is an indivisible whole and made the State responsible for maintaining and helping to restore it. The Ministry of Health and Social Welfare is the agency responsible for fulfilling that mandate and does so by performing executive and indicative functions designed to guarantee the right to health of all the inhabitants of the country.

The efforts of the Government to make health service coverage universal have primarily been aimed at the rural population and the population of the shantytowns of the major cities. For census purposes, rural population is defined as that living in communities with fewer than 1,000 inhabitants; it represents 22.8 per cent (2,444,862) of the total population (1971 Census). However, from the functional standpoint, all the population that lives in communities with fewer than 10,000 inhabitants (numbering 3.7 million and representing 34.7 per cent of the total population) has been included in rural coverage.

To serve this population, three major programs that complement one another have been launched and are under way: the “rural medical posts” program for the population of communities with between 1,000 and 9,999 inhabitants; the “simplified medicine” program for the population of villages and hamlets with between 200 and 999 inhabitants; and the “creation of new villages” program for the present population of hamlets with less than 200 inhabitants or for nomads.

The population increase (3.4 per cent), immigration, and the growing migration of the rural population to the cities and industrial development centers have resulted in the establishment of urban marginal areas containing sizable population groups. A study made in 1977 by the Ministry of Public Works estimated that in those areas there are 2.7 million persons whose economic and social problems demand an immediate solution. To deal with this problem the Government established in 1975 the Program for the Management of Areas occupied by the Low Income Districts of the Country, the basic instrument of which is the “multiple service module.” Each one of these modules is designed to provide comprehensive services to groups of 15,000–20,000 persons. Eighty-six such modules are in operation, and provision has been made for the approval of a further 106 in the years ahead.

Bearing in mind the scope of the services and their accessibility, only the scattered population and that living in communities with fewer than 200 inhabitants, which together amount to 1,252,268 inhabitants and represent 11.7 per cent of the total population (1971), may be considered to have limited access to health services or to receive insufficient or sporadic services. The rest of the population is served by services organized by levels of complexity and supported

VENEZUELA

(Summary of the Report Presented)
by a hospital infrastructure that is being gradually developed. At present the following services are available: 440 hospitals with 3,794 beds; 529 rural medical posts; and 2,391 rural dispensaries of which 625 operate under the simplified medicine program.

2. The strategies of primary health care and community participation are to be found in their purest form in the programs for the establishment of rural villages and simplified medicine. The first, which was institutionalized in 1974, uses a multidisciplinary and multisectoral approach. The planning and execution of the program is the joint responsibility of the National Agrarian Institute; the governments of the states; the Farmers' Federation; and the Ministries of Health and Social Welfare, Education, Agriculture and Stockraising, Public Works, Finance, and the Interior. It is still too early to make a realistic evaluation of this program; nevertheless, the experience already gained has made it possible to define guidelines that will enable efforts to be strengthened in the near future.

The purpose of the simplified medicine program, which was initiated in 1972, is to provide simple but effective comprehensive health services to the inhabitants of those places in which, for sociocultural and administrative reasons, it is difficult to establish permanent services manned by a physician or for them to operate effectively and efficiently. The focal point of the activities of the program is the rural dispensary, which is manned by a trained auxiliary drawn from the community she serves. The dispensary is the portal of entry to a stepped series of institutions of increasing complexity responsible for programming, supervising and supplementing the services of the dispensary as well as for training the auxiliaries responsible for logistics and supplies. At present there are 2,391 dispensaries in 3,106 communities with between 200 and 1,000 inhabitants; of the auxiliaries that operate them, 625 have already received appropriate training. The simplified medicine program is not considered final and unalterable; it is meeting what is considered to be temporary need. The regrouping of the scattered rural population and its organization in centers that provide greater economic and social incentives and better living conditions will make it necessary to transform or create health services manned by professional and technical health personnel. At present, more than one rural dispensary has been converted into a Rural Medical Post.

Finally, the Multiple Services Modules, designed to satisfy the basic needs of communities in urban marginal areas, provide basic health, family planning, early diagnosis of cancer, food supplementation for children, mental health, dental health, emergency care, basic sanitation, health education and other social services. At present the modules cover 1.2 million persons; most consultations (60 per cent) are for preventive services.

3. The extension of health service coverage based on the criteria of universality, comprehensiveness, accessibility, efficiency, and effectiveness, is proceeding parallel with national efforts to accelerate overall socioeconomic development. The effective coordination of institutional health programs and resources is a sine qua non for achieving this integration. This is recognized by the Govern-
Extension of Coverage

ment, which, accordingly, in 1976 established the Coordinated Health Services and the National Health Council, the activities of which have been planned in such a way as to make the establishment of a unified health service possible within a period of three years.

Meanwhile, the necessary steps have been taken to complete the required number of rural medical posts; to train 2,100 simplified medicine auxiliaries for rural dispensaries; to continue, on the basis of a multisectoral approach, the program for the resettlement of the scattered rural population in new villages; and to pursue, in collaboration with the Ministries of Education, Labor, and Interior, and with the governments of the states and the municipalities, the program of Multiple Services Modules until it covers all the population centers in the marginal areas of the urban centers of the country.